Wisconsin Department of Regulation & Licensing
Monitoring
Nursing Work Report Form

If you have any questions regarding this report, please contact the Monitor at 608-267-3817.
Please provide as much detail as possible (use back of page or additional sheets, if necessary).

Employee's Name: _____

Place of Employment: _____

Type of Facility: _____

Date of Employment: _____ Length of Employment: _____

( ) Full-time ( ) Part-time Number of hours per week: _____

Shift: ( ) Days ( ) Evenings ( ) Nights ( ) Rotates

Attendance: Number of days absent the past three months: _____
( ) No pattern of absence ( ) Pattern of absence Describe: _____
Number of days tardy the past three months: _____
( ) No pattern of tardiness ( ) Pattern of tardiness Describe: _____

Quality of Work: ( ) Outstanding ( ) Satisfactory ( ) Needs Improvement
Comments: _____
_____
_____
_____

Interpersonal relationships with co-workers:
( ) Very good ( ) Satisfactory ( ) Needs Improvement
Comments: _____
_____

Individual evaluation conference held in past three months? ( ) Yes ( ) No
Outcome: _____
_____

To the best of your knowledge has the licensee been in compliance with the terms of his/her Order. ( ) Yes ( ) No
If no, please explain: _____
_____
_____

To the best of your knowledge has the licensee been in compliance with the laws and rules governing the practice of the profession. ( ) Yes ( ) No
If no, please explain: _____
_____
_____

Is this employee administering medications? ( ) Yes ( ) No
If the employee is administering medications, have any problems or discrepancies been noted.
Please describe: _____

_____

If employee has an alcohol/drug impairment, please answer these additional questions:

Is this employee administering controlled substances? ( ) Yes ( ) No
If the employee is administering controlled substances, have any problems or discrepancies been noted. Please describe: _____

_____

Does this employee have access to controlled substances? ( ) Yes ( ) No
If Yes, please describe the nature of the access (ex. direct or indirect; limited; supervised or unsupervised) _____

To the best of you knowledge, do you believe the employee is maintaining abstinence from all mood altering chemicals, including alcohol? ( ) Yes ( ) No ( ) Unsure
If you answered no or unsure, please explain: _____

_____

Any further comments, questions or problems? (Please attach additional sheets)

_____ _____
Signature of Supervisor Date

_____ _____
Print name of Supervisor and Title Supervisor's License Number

_____
Supervisor's Place of Employment

_____
Address

( )_____
Phone number

Please feel free to attach any additional information you wish to bring to the Monitor's attention.

Please mail or fax this form every three months to:

ATTN: Department Monitor
Wisconsin Department of Regulation & Licensing
PO Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264